ADVANCE HEALTH CARE DIRECTIVE
for Christian Scientists

GENERAL EXPLANATION

Most, if not all, states have laws and regulations which give its citizens the right to stipulate what kind of health care treatment you will receive. You have the right to give instructions about your own health care. You also have the right to name someone else to make health care decisions for you.

An Advance Health Care Directive ("AHCD") is a generic statutory term for a document that instructs others about your medical care should you be unable to make decisions on your own. It only becomes effective under the circumstances delineated in the AHCD and allows you to do either or both of the following:

1. Appoint a Health Care Agent.

The AHCD allows you to appoint as a health care agent who will have the legal authority to make health care decisions for you if you are no longer able to make your own decisions. The individual named will have authority to make decisions regarding all aspects of your health care.

2. Prepare instructions for health care.

The AHCD allows you to make specific written instructions for your future health care in the event of any situation in which you can no longer speak for yourself. It can outline your desire to rely on Christian Science treatment for healing or any other measures you deem appropriate.

AN EXPLANATION OF THE ATTACHED AHCD

The attached AHCD has been specifically prepared for those individuals who desire to radically rely on Christian Science treatment for healing.

The AHCD lets you name another individual as agent to make health care decisions for you if you become incapable of making your own decisions, or if you want someone else to make those decisions for you now even though you are still capable. You may also name an alternate agent to act for you if your first choice is not willing, able, or reasonably available to make decisions for you. (Your agent may not be your practitioner or an employee of a health care provider if you are receiving care there, unless your agent is related to you, a health care provider.)

The AHCD grants your agent the authority to make health care decisions for you. It grants your appointed agent broad power to make health care decisions for you.

This AHCD grants your agent the power to 1) make decisions regarding your personal care; 2) authorize Christian Science treatment or medical care under certain circumstances; 3) execute certain documents; 4) receive medical information; 5) incur health care expenses and 6) take certain actions in the event of death.

The AHCD also places certain limitations on your agent. Your agent has the obligation to consult with you before making decisions, to follow your wishes and it also limits the agent's authority to prescribe medical treatment on your behalf.

You may revoke or amend the AHCD at any time. This AHCD refers to California law and may not conform to the laws of any other state. Consult with your own personal legal adviser regarding the laws of the state of your residency.

Should you desire to execute the AHCD, the accompanying form provides that your signature be acknowledged before a notary public.

ADVANCE HEALTH CARE DIRECTIVE

By signing this document, I intend to create an advance health care directive ("Directive") under the Health Care Decisions Law, Sections 4600 through 4805 of the California Probate Code. I hereby revoke any and all prior advance health care directives or powers of attorney for health care signed by me. I hereby reserve the right to amend or revoke this Directive.

This Directive shall be effective immediately and shall remain in full force and effect during any period that I am incapacitated or unable to give informed consent to medical treatment.

1. DESIGNATION OF AGENT

I hereby designate the following individual as my Agent to make health care decisions for me and to act in my name as authorized in this Directive.

_____

Name of individual you select as agent

_____

Address City State Zip code

_____

Home phone Work phone Cellphone

OPTIONAL: If for any reason my appointed Agent is, or becomes unable or unwilling to serve as my Agent under this Directive, or is unavailable to act as my Agent, or if I revoke my Agent's appointment or authority to act as my Agent under this Directive, then I designate the following individual to serve as my successor Agent to make such health care decisions for me as authorized under this Directive. All provisions in this Directive applicable to the initial Agent shall likewise be applicable to each and every successor Agent.

_____

Name of individual you choose as alternate agent

_____

Address City State Zip code

_____

Home phone Work phone Cellphone

2. AUTHORITY OF AGENT

My Agent is authorized to make all health care decisions for me, as long as he or she acts in accordance with the practice of Christian Science, except as otherwise stated in this Directive. For purposes of this Directive, the term "health care decision" means to consent, refuse consent, or withdraw consent to any type of medical care, treatment, service, medication, or procedure to affect, maintain, diagnose, or treat any physical, mental or emotional condition, including decisions to provide, withhold, or withdraw artificial nutrition and hydration and all other forms of health care to keep me alive. My Agent shall have the power and authority to do, execute, and perform every act that in his or her best judgment ought to be done to provide for the care, treatment, services or procedures reasonably necessary to maintain, diagnose, treat or otherwise aid my physical, mental or emotional condition. I designate my Agent as my personal representative under 45 CFR 164.502(g), a portion of the regulations implementing the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), for all health care-related decisions.

3. POWERS OF AGENT

My Agent shall have the power and the authority to do all of the following, consistent with my desires as expressed in this Directive or otherwise made known to my Agent:

3.1 Making Decisions as to Personal Care

a) To make decisions relating to my personal care, including, but not limited to, determining where I will live, providing meals, and hiring and supervising household employees and other service providers.

b) To make decisions relating to my other personal needs, including but not limited to, providing or arranging transportation, handling mail, and arranging for recreation and entertainment.

c) To employ and/or discharge any Christian Science practitioner or Christian Science nurse, as my Agent may deem necessary for my physical, mental and emotional well-being.

3.2 Authorizing Christian Science or Medical Treatment

In making health care decisions for me, my Agent is subject to the special provisions and limitations set forth below.

a) I am a member of the Church of Christ, Scientist, also known as the Christian Science denomination. The practice of Christian Science includes healing entirely by prayer or spiritual means. It is my desire to rely exclusively upon Christian Science treatment for all my health care needs. Therefore, in lieu of any and all forms of medical treatment, including those thought necessary to sustain my life, I authorize and direct my Agent to arrange for health care by spiritual means through prayer, exclusively, in accordance with the practice of Christian Science. I desire to have such Christian Science treatment at home, from a Christian Science practitioner. If any nursing care is necessary, I prefer to receive it from a Christian Science nurse, if one is reasonably available, and not from a medical nurse. Should I require care outside the home, I prefer my Agent to arrange such care at a Christian Science nursing facility. I do not wish to be hospitalized or placed in any convalescent or other facility which does not subscribe exclusively to the practices of Christian Science.

b) The foregoing notwithstanding, my Agent, if my Agent determines it is appropriate, may cause me to receive assistance from a medical doctor or a dentist, as the case may be, where such assistance consists of more or less a mechanical nature such as the pulling of a tooth, setting of a broken bone, or the taking of stitches. Such assistance is consistent, in my view with the practice of Christian Science.

c) (additional and/or special directions)

_____

_____

d) Other than as stated above, I do not wish to receive medical life-prolonging care, surgery, medicine, diagnostic testing, shock treatment, or drugs of any kind.

e) I request that no governmental agency nor any other group or individual intervene to cause medical treatment to be given to me or cause me to be hospitalized against my stated wishes or against the instructions and decisions of my Agent. By arranging for Christian Science treatment, even in a situation which may be considered life-threatening, my Agent shall not be subject to civil or criminal liability.

3.3 Executing Documents

To execute, acknowledge, and deliver on my behalf any documents that may be necessary, desirable or proper to exercise any of the powers described in this Directive including, but not limited to a Medicare election form allowing me to receive Medicare benefits for nursing services furnished in a religious nonmedical health care institution.

3.4 Receiving Medical Information

Any third party from whom my Agent may request information, records or other documents regarding my physical, mental or emotional health, including, but not limited to medical and hospital records and other protected health information as defined by HIPAA, is authorized and directed to release and deliver all such information, records or documents to my Agent. As to my Agent, I hereby waive any and all privileges which may apply to the release of such information, records or other documents and to any communication pertaining to me and made in the course of a lawyer-client, physician-patient, psychiatrist-patient, clergyman-penitent or other similar relationship.

3.5 Incurring Expenses and Hiring Health Care Providers

a) To incur expenses for my health and medical care and treatment as authorized under this Directive and to direct or request my conservator, trustee, or agents to pay or reimburse such expenses.

b) To select, employ and discharge Christian Science practitioners, physicians, nurses, dentists, therapists and other health care providers as my Agent determines to be necessary to carry out the health care decisions my Agent makes under this Directive.

c) To summon paramedics or other emergency medical personnel and seek emergency treatment for me or choose not to do so.

d) To arrange for my hospitalization and convalescent care or home care, and to select and discharge hospitals, Christian Science nursing facilities and other health care institutions.

3.6 Taking Actions After the Death of the Principal

a) To receive any and all items of personal property and effects that may be recovered from or about my person by any health care provider or institution, police agency or any other person at the time of my illness, disability or death.

b) To direct the disposition of my remains under Health and Safety Code Section 7100 and to arrange for my funeral and burial and other related arrangements.

4. LIMITATION ON AUTHORITY OF AGENT

Notwithstanding the broad powers and authority granted to my Agent above, in exercising that authority and those powers, my Agent shall act consistently with my desires and is subject to the following limitations.

4.1 Duty to Consult with Me.

Before taking any actions, my Agent shall first discuss or attempt to discuss with me the specifics of any decision to be made and obtain my instructions and wishes unless I am not physically or mentally capable of giving such instructions or am unable to communicate with my Agent.

4.2 Duty to Follow My Instructions.

If I am physically and mentally capable of giving my Agent instructions, my Agent shall follow such instructions and directions without any personal liability whatsoever. If, however, I am not physically or mentally capable of giving such instructions my Agent shall follow, to the best of his or her ability, the instructions I have given in this Directive, or absent such instructions shall act in accordance with my expressed wishes and desires otherwise known to my Agent whether contained in this Directive or not.

4.3 Duty to Follow My Wishes or Act in Best Interest.

If I am unable to communicate instructions and my wishes are otherwise unknown, my Agent shall make health care decisions for me in accordance with this advance health care directive, and my other wishes to the extent known to my Agent. To the extent my wishes are unknown, my Agent shall make health care decisions for me in accordance with what my Agent determines to be in my best interest. In determining my best interest, my Agent shall consider my personal values to the extent known to my Agent.

4.4 Specific Limitations on Medical Treatment.

Notwithstanding anything to the contrary contained herein, I retain the power and authority to continue making my own medical and health care decisions so long as I can give informed consent to medical treatment. When it has been determined that I lack the capacity to give informed consent to medical treatment, my Agent, acting under this Directive, may authorize the discontinuance of medical treatment or refuse consent to further medical treatment if my Agent makes that decision in good faith and based on appropriate medical advice. If and only if I lack the capacity to give informed consent to medical treatment, I hereby grant to my Agent full power and authority to consent, refuse consent or withdraw consent to any type of medical care, treatment, service, medication or procedure to affect, maintain, diagnose or treat any physical, mental or emotional condition.

5. DETERMINATION OF LACK OF CAPACITY

My Agent's authority hereunder is not dependent on a determination of whether I lack the capacity to give informed consent. I recognize that third parties may inquire whether I approve or oppose the care or treatment which the Agent seeks to obtain for me. It is my desire and instruction that third parties rely on the authority of the Agent without evidence of the incapacity, and that they carry out the instructions given by my Agent. Notwithstanding the foregoing provisions, if I require emergency care or treatment, my Agent may determine whether I lack the capacity to make my own health care decisions under the circumstances. In determining whether my physical condition or mental functioning is so severely impaired that I lack the capacity to make my own health care decisions, my Agent may take into consideration the frequency, severity and duration of periods of impairment.

6. RATIFICATION OF ACTIONS

The signature of my Agent under the authority granted in this Directive may be accepted by any third party or organization as fully authorized by me and with the same force and effect as if I were personally present, competent and acting on my own behalf. I hereby ratify and confirm all that my Agent, or his successors shall do or cause to be done by virtue and authority of this Directive and the rights and powers granted herein. I further confirm that each and every action taken by my Agent or successors thereto under this Directive shall be binding upon me and my estate, heirs, beneficiaries, successors and assigns. For myself, my estate, personal representatives, heirs, beneficiaries, successors and assigns, I hereby absolve and release my Agent, physicians and any hospital or other health care institution from any legal liability whatsoever on account of following my wishes expressed in this Directive.

7. RELIANCE BY THIRD PARTIES

In order to induce reliance by third parties on this Directive, it is agreed and understood that no person or organization who relies on the authority of my Agent under this Directive or any representation my Agent makes regarding his authority shall incur any liability to me, my estate, heirs, beneficiaries, successors or assigns because of such reliance on this Directive or on any such representation by my Agent, including, but not limited to : (1) the fact that this Directive has not been revoked; (2) that I was competent to execute this Directive; or (3) the authority of my Agent under this Directive. I and my estate, heirs, beneficiaries, successors and assigns will hold such party or parties harmless from any loss suffered or liability incurred because of such

reliance. Any third party receiving a duly executed copy or photocopy of this Directive may act in reliance on such copy or photocopy. A copy of this document has the same effect as the original. Any revocation or termination of this Directive by operation of law or otherwise shall not be by HIPAA knowledge of my death or such revocation or termination.

8. PRIORITY OF AGENT

My Agent, including any successor Agent, if available and willing to make health care decisions on my behalf shall have priority over any other person to act for me in all matters of health care decisions where I am unable to give informed consent with respect to such decisions. Nothing in this Directive shall affect any right my Agent may have, apart from this Directive, to make or participate in the making of health care decisions on my behalf. Moreover, this Directive does not affect the right which any person may have to make health care decisions on my behalf if my Agent and any successor Agent are unavailable, unwilling or unable to make health care decisions on my behalf. (This Directive also does not affect the law governing health care treatment in emergency.) I desire that my wishes as expressed in this Directive be carried out through the authority given to my Agent in this Directive despite any contrary feelings, beliefs or opinions of members of my family, relatives, friends or conservator. My Agent shall have authority over my health care decisions even if someone else is appointed by a court to act as conservator of my person or estate.

9. DECLARATIONS BY PRINCIPAL

I declare that I have read this Directive and understand its importance. I recognize that my Agent is granted broad power and authority to make health care decisions affecting me. I also recognize that this Directive will remain in full force and effect during my incapacity and continue unless revoked. By signing below, I further declare that I am emotionally and mentally competent to execute this Directive and understand its purpose and effect. I am not currently a patient in a skilled nursing facility.

IN WITNESS WHEREOF, I have executed this Directive

on this _____ day of _____, 20____, at _____, California.

_____ _____

Signature Print name

ACKNOWLEDGMENT

A notary public or other officer completing this certificate verifies only the identity of the individual who signed the document to which this certificate is attached, and not the truthfulness, accuracy, or validity of that document.

State of California

County of _____)

On _____ before me, _____,
date (insert name and title of the officer)

personally appeared _____, who proved to me on the basis of satisfactory evidence to be the person(s) whose name(s) is/are subscribed to the within instrument and acknowledged to me that he/she/they executed the same in his/her/their capacity(ies), and that by his/her/their signature(s) on the instrument the person(s), or the entity upon behalf of which the person(s) acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____

Place Notary Seal Above Signature of Notary Public